STATEMENT OF EMERGENCY

907 KAR 15:020E

(1) This emergency administrative regulation is being promulgated in conjunction with 907 KAR 15:025E, Reimbursement provisions and requirements regarding behavioral health services provided by behavioral health service organizations, to comply with a federal mandate. 907 KAR 15:020E and 907 KAR 15:025E are necessary to establish Kentucky Medicaid Program coverage and reimbursement of behavioral health services (including substance use disorder services) provided by behavioral health service organizations. The Affordable Care Act mandates coverage of substance use disorder services for all Medicaid recipients (who meet qualifying criteria) and federal law requires Medicaid Programs to ensure that recipients have access to services. DMS is adding behavioral health service organizations to the behavioral health provider base to ensure that there is an adequate supply of providers to meet Medicaid recipient demand for care – as federally required.

(2) This action must be taken on an emergency basis to prevent a loss of Medicaid federal funds and to meet a deadline for the promulgation of an administrative regulation necessary under federal law and regulation.

(3) This emergency administrative regulation shall be replaced by an ordinary administrative regulation filed with the Regulations Compiler.

(4) The ordinary administrative regulation is identical to this emergency administrative regulation.

Steven L. Beshear
Governor

Audrey Tayse Haynes, Secretary
Cabinet for Health and Family Services

CABINET FOR HEALTH AND FAMILY SERVICES

Department for Medicaid Services

Division of Policy and Operations

(New Emergency Administrative Regulation)

907 KAR 15:020E. Coverage provisions and requirements regarding services provided by behavioral health service organizations.

RELATES TO: KRS 205.520, 42 U.S.C. 1396a(a)(10)(B), 42 U.S.C. 1396a(a)(23)

STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3)

NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family Services, Department for Medicaid Services, has a responsibility to administer the Medicaid Program. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with any requirement that may be imposed or opportunity presented by federal law to qualify for federal Medicaid funds. This administrative regulation establishes the coverage provisions and requirements regarding Medicaid Program behavioral health services provided by behavioral health services organizations.

Section 1. General Coverage Requirements. (1) For the department to reimburse for a service covered under this administrative regulation, the service shall be:

(a) Medically necessary; and

(b) Provided:

1. To a recipient; and

2. By a behavioral health services organization that meets the provider participation

requirements established in Section 2 of this administrative regulation.

(2)(a) Direct contact between a practitioner and a recipient shall be required for each service except for a collateral service for a child under the age of twenty-one (21) years if the collateral service is in the child's plan of care.

(b) A service that does not meet the requirement in paragraph (a) of this subsection shall not be covered.

(3) A billable unit of service shall be actual time spent delivering a service in a face-to-face encounter.

(4) A service shall be:

(a) Stated in the recipient's treatment plan; and

(b) Provided in accordance with the recipient's treatment plan.

Section 2. Provider Participation. (1) To be eligible to provide services under this administrative regulation, a behavioral health services organization shall:

(a) Be currently enrolled in the Kentucky Medicaid Program in accordance with 907 KAR 1:672;

(b) Except as established in subsection (2) of this section, be currently participating in the Kentucky Medicaid Program in accordance with 907 KAR 1:671;

(c) Licensed as a behavioral health services organization in accordance with 902 KAR 20:430; and

(d) Have:

1. For each service it provides, the capacity to provide the full range of the service as established in this administrative regulation;

2. Demonstrated experience in serving individuals with behavioral health disorders;

3. The administrative capacity to ensure quality of services;

4. A financial management system that provides documentation of services and costs; and

5. The capacity to document and maintain individual case records.

(2) In accordance with 907 KAR 17:015, Section 3(3), a behavioral health services organization which provides a service to an enrollee shall not be required to be currently participating in the fee-for-service Medicaid Program.

(3) A behavioral health services organization shall:

(a) Agree to provide services in compliance with federal and state laws regardless of age, sex, race, creed, religion, national origin, handicap, or disability; and

(b) Comply with the Americans with Disabilities Act (42 U.S.C. 12101 et seq.) and any amendments to the Act.

Section 3. Covered Services. (1) Except as specified in the requirements stated for a given service, the services covered may be provided for a:

(a) Mental health disorder;

(b) Substance use disorder; or

(c) Co-occurring mental health and substance use disorders.

(2) The following services shall be covered under this administrative regulation in accordance with the corresponding following requirements:

(a) A screening, crisis intervention, or intensive outpatient program services provided by:

1. A licensed psychologist;

2. A licensed psychological practitioner;

3. A licensed clinical social worker;

4. A licensed professional clinical counselor;

5. A licensed professional art therapist;

6. A licensed marriage and family therapist;

7. A physician;

8. A psychiatrist;

9. An advanced practice registered nurse; or

10. A behavioral health practitioner under supervision except for a licensed assistant behavior analyst;

(b) An assessment provided by:

1. A licensed psychologist;

2. A licensed psychological practitioner;

3. A licensed clinical social worker;

4. A licensed professional clinical counselor;

5. A licensed professional art therapist;

6. A licensed marriage and family therapist;

7. A physician;

8. A psychiatrist;

9. An advanced practice registered nurse;

10. A licensed behavior analyst; or

11. A behavioral health practitioner under supervision except for a certified alcohol and drug counselor;

(c) Psychological testing provided by:

1. A licensed psychologist;

2. A licensed psychological associate working under the supervision of a licensed psychologist; or

3. A licensed psychological practitioner;

(d) Day treatment, mobile crisis services, or residential services for substance use disorders provided by:

1. A licensed psychologist;

2. A licensed psychological practitioner;

3. A licensed clinical social worker;

4. A licensed professional clinical counselor;

5. A licensed professional art therapist;

6. A licensed marriage and family therapist;

7. A physician;

8. A psychiatrist;

9. An advanced practice registered nurse;

10. A behavioral health practitioner under supervision except for a licensed assistant behavior analyst;

11. A peer support specialist working under the supervision of an approved behavioral health services provider;

(e) Peer support provided by a peer support specialist working under the supervision of an approved behavioral health service provider;

(f) Individual outpatient therapy, group outpatient therapy, or collateral outpatient therapy provided by:

1. A licensed psychologist;

2. A licensed psychological practitioner;

3. A licensed clinical social worker;

4. A licensed professional clinical counselor;

5. A licensed professional art therapist;

6. A licensed marriage and family therapist;

7. A physician;

8. A psychiatrist;

9. An advanced practice registered nurse;

10. A licensed behavior analyst; or

11. A behavioral health practitioner under supervision except for a certified alcohol and drug counselor;

(g) Family outpatient therapy provided by:

1. A licensed psychologist;

2. A licensed psychological practitioner;

3. A licensed clinical social worker;

4. A licensed professional clinical counselor;

5. A licensed professional art therapist;

6. A licensed marriage and family therapist;

7. A physician;

8. A psychiatrist;

9. An advanced practice registered nurse; or

10. A behavioral health practitioner under supervision except for a:

a. Licensed assistant behavior analyst; or

b. Certified alcohol and drug counselor;

(h) Service planning provided by:

1. A licensed psychologist;

2. A licensed psychological practitioner;

3. A licensed clinical social worker;

4. A licensed professional clinical counselor;

5. A licensed professional art therapist;

6. A licensed marriage and family therapist;

7. A physician;

8. A psychiatrist;

9. An advanced practice registered nurse;

10. A licensed behavior analyst; or

11. A behavioral health practitioner under supervision except for a certified alcohol and drug counselor;

(i) A screening, brief intervention, and referral to treatment for a substance use disorder provided by:

1. A licensed psychologist;

2. A licensed psychological practitioner;

3. A licensed clinical social worker;

4. A licensed professional clinical counselor;

5. A licensed professional art therapist;

6. A licensed marriage and family therapist;

7. A physician;

8. A psychiatrist;

9. An advanced practice registered nurse; or

10. A behavioral health practitioner under supervision except for a licensed assistant behavior analyst;

(j) Assertive community treatment provided by:

1. A licensed psychologist;

2. A licensed psychological practitioner;

3. A licensed clinical social worker;

4. A licensed professional clinical counselor;

5. A licensed professional art therapist;

6. A licensed marriage and family therapist;

7. A physician;

8. A psychiatrist;

9. An advanced practice registered nurse;

10. A behavioral health practitioner under supervision except for a:

a. Licensed assistant behavior analyst; or

b. Certified alcohol and drug counselor;

11. A peer support specialist working under the supervision of an approved behavioral health service provider; or

12. A community support associate;

(k) Comprehensive community support services provided by:

1. A licensed psychologist;

2. A licensed psychological practitioner;

3. A licensed clinical social worker;

4. A licensed professional clinical counselor;

5. A licensed professional art therapist;

6. A licensed marriage and family therapist;

7. A physician;

8. A psychiatrist;

9. An advanced practice registered nurse;

10. A licensed behavior analyst;

11. A behavioral health practitioner under supervision except for a certified alcohol and drug counselor; or

12. Community support associate; or

(l) Therapeutic rehabilitation program services provided by:

1. A licensed psychologist;

2. A licensed psychological practitioner;

3. A licensed clinical social worker;

4. A licensed professional clinical counselor;

5. A licensed professional art therapist;

6. A licensed marriage and family therapist;

7. A physician;

8. A psychiatrist;

9. An advanced practice registered nurse;

10. A behavioral health practitioner under supervision except for a:

a. Licensed assistant behavior analyst; or

b. Certified alcohol and drug counselor;

11. A peer support specialist working under the supervision of an approved behavioral health services provider.

(3)(a) A screening shall:

1. Be the determination of the likelihood that an individual has a mental health disorder, substance use disorder, or co-occurring disorders;

2. Not establish the presence or specific type of disorder; and

3. Establish the need for an in-depth assessment.

(b) An assessment shall:

1. Include gathering information and engaging in a process with the individual that enables the practitioner to:

a. Establish the presence or absence of a mental health disorder, substance use disorder, or co-occurring disorders;

b. Determine the individual's readiness for change;

c. Identify the individual's strengths or problem areas that may affect the treatment and recovery processes; and

d. Engage the individual in developing an appropriate treatment relationship;

2. Establish or rule out the existence of a clinical disorder or service need;

3. Include working with the individual to develop a treatment and service plan; and

4. Not include psychological or psychiatric evaluations or assessments.

(c) Psychological testing shall include:

1. A psychodiagnostic assessment of personality, psychopathology, emotionality, or

intellectual disabilities; and

2. Interpretation and a written report of testing results.

(d) Crisis intervention:

1. Shall be a therapeutic intervention for the purpose of immediately reducing or eliminating the risk of physical or emotional harm to:

a. The recipient; or

b. Another individual;

2. Shall consist of clinical intervention and support services necessary to provide integrated crisis response, crisis stabilization interventions, or crisis prevention activities for individuals;

3. Shall be provided:

a. On-site at the behavioral health services organization's office;

b. As an immediate relief to the presenting problem or threat; and

c. In a face-to-face, one (1) on one (1) encounter between the provider and the recipient;

4. Shall be followed by a referral to non-crisis services if applicable; and

5. May include:

a. Further service prevention planning including:

(i) Lethal means reduction for suicide risk; or

(ii) Substance use disorder relapse prevention; or

b. Verbal de-escalation, risk assessment, or cognitive therapy;

(e) Mobile crisis services shall:

1. Be available twenty-four (24) hours a day, seven (7) days a week, every day of the

year;

2. Be provided for a duration of less than twenty-four (24) hours;

3. Not be an overnight service; and

4. Be a crisis response in a home or community setting to provide an immediate evaluation, triage, and access to behavioral health services including treatment and supports to:

(i) Reduce symptoms or harm; or

(ii) Safely transition an individual in an acute crisis to the appropriate least restrictive level of care.

(f)1. Day treatment shall be a non-residential, intensive treatment program for a child under the age of twenty-one (21) years who has:

a. A mental health disorder, substance use disorder, or co-occurring mental health and substance use disorders; and

b. A high risk of out-of-home placement due to a behavioral health issue.

2. Day treatment shall:

a. Consist of an organized, behavioral health program of treatment and rehabilitative services (substance use disorder, mental health, or co-occurring mental health and substance use disorders);

b. Include:

(i) Individual outpatient therapy, family outpatient therapy, or group outpatient therapy;

(ii) Behavior management and social skill training;

(iii) Independent living skills that correlate to the age and development stage of the

recipient; or

(iv) Services designed to explore and link with community resources before discharge and to assist the recipient and family with transition to community services after discharge; and

c. Be provided:

(i) In collaboration with the education services of the local education authority including those provided through 20 U.S.C. 1400 et seq. (Individuals with Disabilities Education Act) or 29 U.S.C. 701 et seq. (Section 504 of the Rehabilitation Act);

(ii) On school days and during scheduled school breaks;

(iii) In coordination with the recipient's individualized educational plan if the recipient has an individualized educational plan;

(iv) Under the supervision of a licensed or certified behavioral health practitioner or a behavioral health practitioner working under clinical supervision; and

(v) With a linkage agreement with the local education authority that specifies the responsibilities of the local education authority and the day treatment provider.

3. To provide day treatment services, a behavioral health services organization shall have:

a. The capacity to employ staff authorized to provide day treatment services in accordance with this section and to coordinate the provision of services among team members; and

b. Knowledge of substance use disorders.

4. Day treatment shall not include a therapeutic clinical service that is included in a child's individualized education plan.

(g)1. Peer support services shall:

a. Be social and emotional support that is provided by an individual who is experiencing a mental health disorder, substance use disorder, or co-occurring mental health and substance use disorders to a recipient by sharing a similar mental health disorder, substance use disorder, or co-occurring mental health and substance use disorders in order to bring about a desired social or personal change;

b. Be an evidence-based practice;

c. Be structured and scheduled non-clinical therapeutic activities with an individual recipient or a group of recipients;

d. Be provided by a self-identified consumer, parent, or family member:

(i) Of a child consumer of mental health disorder services, substance use disorder services, or co-occurring mental health disorder services and substance use disorder services; and

(ii) Who has been trained and certified in accordance with 908 KAR 2:220, 908 KAR 2:230, or 908 KAR 2:240;

e. Promote socialization, recovery, self-advocacy, preservation, and enhancement of community living skills for the recipient;

f. Be coordinated within the context of a comprehensive, individualized treatment plan developed through a person-centered planning process;

g. Be identified in each recipient's treatment plan; and

h. Be designed to directly contribute to the recipient's individualized goals as specified in the recipient's treatment plan.

2. To provide peer support services a behavioral health services organization shall:

a. Have demonstrated:

(i) The capacity to provide peer support services for the behavioral health population being served including the age range of the population being served; and

(ii) Experience in serving individuals with behavioral health disorders;

b. Employ peer support specialists who are qualified to provide peer support services in accordance with 908 KAR 2:220, 908 2:230, or 908 2:240;

c. Use an approved behavioral health services provider to supervise peer support specialists;

d. Have the capacity to coordinate the provision of services among team members; and

e. Have the capacity to provide on-going continuing education and technical assistance to peer support specialists.

(h)1. Intensive outpatient program services shall:

a. Be an alternative to or transition from inpatient hospitalization or partial hospitalization for a mental health disorder, substance use disorder, or co-occurring disorders;

b. Offer a multi-modal, multi-disciplinary structured outpatient treatment program that is significantly more intensive than individual outpatient therapy, group outpatient therapy, or family outpatient therapy;

c. Be provided at least three (3) hours per day at least three (3) days per week; and

d. Include:

(i) Individual outpatient therapy, group outpatient therapy, or family outpatient therapy unless contraindicated;

(ii) Crisis intervention; or

(iii) Psycho-education.

2. During psycho-education the recipient or recipient's family member shall be:

a. Provided with knowledge regarding the recipient's diagnosis, the causes of the condition, and the reasons why a particular treatment might be effective for reducing symptoms; and

b. Taught how to cope with the recipient's diagnosis or condition in a successful manner.

3. An intensive outpatient program services treatment plan shall:

a. Be individualized; and

b. Focus on stabilization and transition to a lesser level of care.

4. To provide intensive outpatient program services, a behavioral health services organization shall have:

a. Access to a board-certified or board-eligible psychiatrist for consultation;

b. Access to a psychiatrist, other physician, or advanced practiced registered nurse for medication prescribing and monitoring;

c. Adequate staffing to ensure a minimum recipient-to-staff ratio of ten (10) recipients to one (1) staff person;

d. The capacity to provide services utilizing a recognized intervention protocol based on nationally accepted treatment principles; and

e. The capacity to employ staff authorized to provide intensive outpatient program services in accordance with this section and to coordinate the provision of services among team members.

(i) Individual outpatient therapy shall:

1. Be provided to promote the:

a. Health and wellbeing of the individual; and

b. Recovery from a substance related disorder, mental health disorder, or co-occurring related disorders;

2. Consist of:

a. A face-to-face, one (1) on one (1) encounter between the provider and recipient; and

b. A behavioral health therapeutic intervention provided in accordance with the recipient's identified treatment plan;

3. Be aimed at:

a. Reducing adverse symptoms;

b. Reducing or eliminating the presenting problem of the recipient; and

c. Improving functioning; and

4. Not exceed three (3) hours per day unless additional time is medically necessary.

(j)1. Group outpatient therapy shall:

a. Be a behavioral health therapeutic intervention provided in accordance with a recipient's identified treatment plan;

b. Be provided to promote the:

(i) Health and wellbeing of the individual; and

(ii) Recovery from a substance related disorder, mental health disorder, or co-occurring related disorders;

c. Consist of a face-to-face behavioral health therapeutic intervention provided in accordance with the recipient's identified treatment plan;

d. Be provided to a recipient in a group setting:

(i) Of nonrelated individuals; and

(ii) Not to exceed twelve (12) individuals in size;

e. Focus on the psychological needs of the recipients as evidenced in each recipient's treatment plan;

f. Center on goals including building and maintaining healthy relationships, personal goals setting, and the exercise of personal judgment;

g. Not include physical exercise, a recreational activity, an educational activity, or a social activity; and

h. Not exceed three (3) hours per day per recipient unless additional time is medically necessary.

2. The group shall have a:

a. Deliberate focus; and

b. Defined course of treatment.

3. The subject of group outpatient therapy shall relate to each recipient participating in the group.

4. The provider shall keep individual notes regarding each recipient within the group and within each recipient's health record.

(k)1. Family outpatient therapy shall consist of a face-to-face behavioral health therapeutic intervention provided:

a. Through scheduled therapeutic visits between the therapist and the recipient and at least one (1) member of the recipient's family; and

b. To address issues interfering with the relational functioning of the family and to im-

prove interpersonal relationships within the recipient's home environment.

2. A family outpatient therapy session shall be billed as one (1) service regardless of the number of individuals (including multiple members from one (1) family) who participate in the session.

3. Family outpatient therapy shall:

a. Be provided to promote the:

(i) Health and wellbeing of the individual; or

(ii) Recovery from a substance use disorder, mental health disorder, or co-occurring related disorders; and

b. Not exceed three (3) hours per day per individual unless additional time is medically necessary.

(l)1. Collateral outpatient therapy shall:

a. Consist of a face-to-face behavioral health consultation:

(i) With a parent or caregiver of a recipient, household member of a recipient, legal representative of a recipient, school personnel, treating professional, or other person with custodial control or supervision of the recipient; and

(ii) That is provided in accordance with the recipient's treatment plan;

b. Not be reimbursable if the therapy is for a recipient who is at least twenty-one (21) years of age; and

c. Not exceed three (3) hours per day per individual unless additional time is medically necessary.

2. Consent to discuss a recipient's treatment with any person other than a parent or legal guardian shall be signed and filed in the recipient's health record.

(m)1. Service planning shall:

a. Involve assisting a recipient in creating an individualized plan for services needed for maximum reduction of a mental health disability;

b. Involve restoring a recipient's functional level to the recipient's best possible functional level; and

c. Be performed using a person-centered planning process.

2. A service plan:

a. Shall be directed by the recipient;

b. Shall include practitioners of the recipient's choosing; and

c. May include:

(i) A mental health advance directive being filed with a local hospital;

(ii) A crisis plan; or

(iii) A relapse prevention strategy or plan.

(n)1. Residential services for substance use disorders shall:

a. Be provided in a twenty-four (24) hour per day unit that is a live-in facility that offers a planned and structured regimen of care aimed to treat individuals with addiction or co-occurring mental health and substance use disorders;

b. Be short or long-term to provide intensive treatment and skills building in a structured and supportive environment;

c. Assist an individual in abstaining from alcohol or substance use and in entering alcohol or drug addiction recovery;

d. Assist a recipient in making necessary changes in the recipient's life to enable the recipient to live drug- or alcohol-free;

e. Be provided under the medical direction of a physician;

f. Provide continuous nursing services;

g. Be based on individual need and may include:

(i) A screening;

(ii) An assessment;

(iii) Service planning;

(iv) Individual outpatient therapy;

(v) Group outpatient therapy;

(vi) Family outpatient therapy; or

(vii) Peer support; and

i. Be provided in accordance with 908 KAR 1:370.

2. The physical structure in which residential services for substance use disorders is provided shall:

a. Have more than eight (8) but less than seventeen (17) beds; and

b. Not be part of multiple units comprising one (1) facility with more than sixteen (16) beds in aggregate.

3. A short-term length-of-stay for residential services for substance use disorders:

a. Shall be less than (30) days in duration;

b. Shall include planned clinical program activities constituting at least fifteen (15) hours per week of structured professionally-directed treatment activities to:

(i) Stabilize a recipient's substance use disorder; and

(ii) Help the recipient develop and apply recovery skills; and

c. May include the services listed in subparagraph 1.h. of this paragraph.

4. A long-term length-of-stay for residential services for substance use disorders:

a. Shall be between thirty (30) days and ninety (90) days in duration;

b. Shall include planned clinical program activities constituting at least forty (40) hours per week of structured professionally-directed treatment activities to:

(i) Stabilize a recipient's substance use disorder; and

(ii) Help the recipient develop and apply recovery skills; and

c. May include the services listed in subparagraph 1.h. of this paragraph.

5. Residential services for substance use disorders shall not include:

a. Room and board;

b. Educational services;

c. Vocational services;

d. Job training services;

e. Habilitation services;

f. Services to an inmate in a public institution pursuant to 42 C.F.R. 435.1010;

g. Services to an individual residing in an institution for mental diseases pursuant to 42 C.F.R. 435.1010;

h. Recreational activities;

i. Social activities; or

j. Services required to be covered elsewhere in the Medicaid state plan.

6. To provide residential services for substance use disorders, a behavioral health services organization shall:

a. Have the capacity to employ staff authorized to provide services in accordance with this section and to coordinate the provision of services among team members; and

b. Be licensed as a non-medical and non-hospital based alcohol and other drug abuse treatment program in accordance with 908 KAR 1:370.

(o) Screening, brief intervention, and referral to treatment for a substance use disorder shall:

1. Be an evidence-based early intervention approach for an individual with non-dependent substance use to provide an effective strategy for intervention prior to the need for more extensive or specialized treatment; and

2. Consist of:

a. Using a standardized screening tool to assess an individual for risky substance use behavior;

b. Engaging a recipient, who demonstrates risky substance use behavior, in a short conversation and providing feedback and advice; and

c. Referring a recipient to additional mental health disorder, substance use disorder, or co-occurring disorders' services if the recipient is determined to need additional services to address substance use.

(p)1. Assertive community treatment shall:

a. Be an evidence-based psychiatric rehabilitation practice which provides a comprehensive approach to service delivery for individuals with a serious mental illness; and

b. Include:

(i) Assessment;

(ii) Treatment planning;

(iii) Case management;

(iv) Psychiatric services;

(v) Medication prescribing and monitoring;

(vi) Individual outpatient therapy;

(vii) Family outpatient therapy;

(viii) Group outpatient therapy;

(ix) Mobile crisis services;

(x) Crisis intervention;

(xi) Mental health consultation; or

(xii) Family support and basic living skills.

2.a. Mental health consultation shall involve brief, collateral interactions with other treating professionals who may have information for the purpose of treatment planning and service delivery.

b. Family support shall involve the assertive community treatment team's working with the recipient's natural support systems to improve family relations in order to:

(i) Reduce conflict; and

(ii) Increase the recipient's autonomy and independent functioning.

c. Basic living skills shall be rehabilitative services focused on teaching activities of daily living necessary to maintain independent functioning and community living.

3. To provide assertive community treatment services, a behavioral health services organization shall:

a. Employ at least one (1) team of multidisciplinary professionals:

(i) Led by a qualified mental health professional; and

(ii) Comprised of at least four (4) full-time equivalents including a prescriber, a nurse, an approved behavioral health services provider, a case manager, or a co-occurring

disorder specialist;

b. Have adequate staffing to ensure that no team's caseload size exceeds ten (10) participants per team member (for example, if the team includes five (5) individuals the caseload for the team shall not exceed fifty (50) recipients);

c. Have the capacity to:

(i) Employ staff authorized to provide assertive community treatment services in accordance with this paragraph;

(ii) Coordinate the provision of services among team members;

(iii) Provide the full range of assertive community treatment services as stated in this paragraph; and

(iv) Document and maintain individual case records; and

d. Demonstrate experience in serving individuals with persistent and serious mental illness who have difficulty living independently in the community.

(q)1. Comprehensive community support services shall:

a. Be activities necessary to allow an individual to live with maximum independence in the community;

b. Be intended to ensure successful community living through the utilization of skills training as identified in the recipient's treatment plan; and

c. Consist of using a variety of psychiatric rehabilitation techniques to:

(i) Improve daily living skills;

(ii) Improve self-monitoring of symptoms and side effects;

(iii) Improve emotional regulation skills;

(iv) Improve crisis coping skills; and

(v) Develop and enhance interpersonal skills.

2. To provide comprehensive community support services, a behavioral health services organization shall:

a. Have the capacity to employ staff authorized pursuant to 908 KAR 2:250 to provide comprehensive community support services in accordance with subsection (2)(m) of this section and to coordinate the provision of services among team members; and

b. Meet the requirements for comprehensive community support services established in 908 KAR 2:250.

(r)1. Therapeutic rehabilitation program services shall be:

a. A rehabilitative service for an:

(i) Adult with a serious mental illness; or

(ii) Individual under the age of twenty-one (21) years who has a serious emotional disability; and

b. Designed to maximize the reduction of a mental health disability and the restoration of the individual's functional level to the individual's best possible functional level.

2. A recipient in a therapeutic rehabilitation program shall establish the recipient's own rehabilitation goals within the person-centered service plan.

3. A therapeutic rehabilitation program shall:

a. Be delivered using a variety of psychiatric rehabilitation techniques;

b. Focus on:

(i) Improving daily living skills;

(ii) Self-monitoring of symptoms and side effects;

(iii) Emotional regulation skills;

(iv) Crisis coping skill; and

(v) Interpersonal skills; and

c. Be delivered individually or in a group.

(4)(a) The requirements established in 908 KAR 1:370 shall apply to any provider of a service to a recipient for a substance use disorder or co-occurring mental health disorder and substance use disorder.

(b) The detoxification program requirements established in 908 KAR 1:370 shall apply to a provider of a detoxification service.

(5) The extent and type of a screening shall depend upon the problem of the individual seeking or being referred for services.

(6) A diagnosis or clinic impression shall be made using terminology established in the most current edition of the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders.

(7) The department shall not reimburse for a service billed by or on behalf of an entity or individual who is not a billing provider.

Section 4. Additional Limits and Non-covered Services or Activities. (1)(a) Except as established in paragraph (b) of this subsection, unless a diagnosis is made and documented in the recipient's medical record within three (3) visits, the service shall not be covered.

(b) The requirement established in paragraph (a) of this subsection shall not apply to:

1. Mobile crisis services;

2. Crisis intervention;

3. A screening; or

4. An assessment.

(2) For a recipient who is receiving residential services for substance use disorders, the following shall not be billed or reimbursed for the same date of service for the recipient:

(a) A screening;

(b) An assessment;

(c) Service planning;

(d) A psychiatric service;

(e) Individual outpatient therapy;

(f) Group outpatient therapy;

(g) Family outpatient therapy; or

(h) Peer support services.

(3) For a recipient who is receiving assertive community treatment, the following shall not be billed or reimbursed for the same date of service for the recipient:

(a) An assessment;

(b) Case management;

(c) Individual outpatient therapy;

(d) Group outpatient therapy;

(e) Peer support services; or

(f) Mobile crisis services.

(4) The department shall not reimburse for both a screening and a screening, brief intervention, and referral to treatment for a substance use disorder provided to a recipient on the same date of service.

(5) The following services or activities shall not be covered under this administrative regulation:

(a) A service provided to:

1. A resident of:

a. A nursing facility; or

b. An intermediate care facility for individuals with an intellectual disability;

2. An inmate of a federal, local, or state:

a. Jail;

b. Detention center; or

c. Prison; or

3. An individual with an intellectual disability without documentation of an additional psychiatric diagnosis;

(b) Psychiatric or psychological testing for another agency, including a court or school, that does not result in the individual receiving psychiatric intervention or behavioral health therapy from the behavioral health services organization;

(c) A consultation or educational service provided to a recipient or to others;

(d) A telephone call, an email, a text message, or other electronic contact that does not meet the requirements stated in the definition of "face-to-face";

(e) Travel time;

(f) A field trip;

(g) A recreational activity;

(h) A social activity; or

(i) A physical exercise activity group.

(6)(a) A consultation by one (1) provider or professional with another shall not be covered under this administrative regulation.

(b) A third party contract shall not be covered under this administrative regulation.

(7) A billing supervisor arrangement between a billing supervisor and a behavioral health practitioner under supervision shall not violate the supervision rules or policies of the respective professional licensure boards governing the billing supervisor and the behavioral health practitioner under supervision.

Section 5. No Duplication of Service. (1) The department shall not reimburse for a service provided to a recipient by more than one (1) provider, of any program in which the service is covered, during the same time period.

(2) For example, if a recipient is receiving a behavioral health service from an independent behavioral health provider, the department shall not reimburse for the same service provided to the same recipient during the same time period by a behavioral health services organization.

Section 6. Records Maintenance, Documentation, Protection, and Security. (1) A behavioral health services organization shall maintain a current health record for each recipient.

(2(a) A health record shall document each service provided to the recipient including the date of the service and the signature of the individual who provided the service.

(b) The individual who provided the service shall date and sign the health record on the date that the individual provided the service.

(3) A health record shall:

(a) Include:

1. An identification and intake record including:

a. Name;

b. Social Security number;

c. Date of intake;

d. Home (legal) address;

e. Health insurance or Medicaid information;

f. Referral source and address of referral source;

g. Primary care physician and address;

h. The reason the individual is seeking help including the presenting problem and diagnosis;

i. Any physical health diagnosis, if a physical health diagnosis exists for the individual, and information regarding:

(i) Where the individual is receiving treatment for the physical health diagnosis; and

(ii) The physical health provider; and

j. The name of the informant and any other information deemed necessary by the behavioral health services organization to comply with the requirements of:

(i) This administrative regulation;

(ii) The behavioral health services organization's licensure board;

(iii) State law; or

(iv) Federal law;

2. Documentation of the:

a. Screening;

b. Assessment if an assessment was performed;

c. Disposition if a disposition was performed; and

d. Six (6) month review of a recipient's treatment plan each time a six (6) month review occurs;

3. A complete history including mental status and previous treatment;

4. An identification sheet;

5. A consent for treatment sheet that is accurately signed and dated; and

6. The individual's stated purpose for seeking services; and

(b) Be:

1. Maintained in an organized central file;

2. Furnished to the:

a. Cabinet for Health and Family Services upon request; or

b. Managed care organization in which the recipient is enrolled upon request if the recipient is enrolled with a managed care organization;

3. Made available for inspection and copying by:

a. Cabinet for Health and Family Services' personnel; or

b. Personnel of the managed care organization in which the recipient is enrolled if the recipient is enrolled with a managed care organization;

4. Readily accessible; and

5. Adequate for the purpose of establishing the current treatment modality and progress of the recipient if the recipient received services beyond a screening.

(4) Documentation of a screening shall include:

(a) Information relative to the individual's stated request for services; and

(b) Other stated personal or health concerns if other concerns are stated.

(5)(a) A behavioral health services organization's notes regarding a recipient shall:

1. Be made within forty-eight (48) hours of each service visit; and

2. Describe the:

a. Recipient's symptoms or behavior, reaction to treatment, and attitude;

b. Therapist's intervention;

c. Changes in the treatment plan if changes are made; and

d. Need for continued treatment if continued treatment is needed.

(b)1. Any edit to notes shall:

a. Clearly display the changes; and

b. Be initialed and dated by the person who edited the notes.

2. Notes shall not be erased or illegibly marked out.

(c)1. Notes recorded by a practitioner working under supervision shall be co-signed and dated by the supervising professional.

2. If services are provided by a practitioner working under supervision, there shall be a monthly supervisory note recorded by the supervision professional reflecting consultations with the practitioner working under supervision concerning the:

a. Case; and

b. Supervising professional's evaluation of the services being provided to the recipient.

(6) Immediately following a screening of a recipient, the practitioner shall perform a disposition related to:

(a) A provisional diagnosis;

(b) A referral for further consultation and disposition, if applicable; or

(c)1. If applicable, termination of services and referral to an outside source for further services; or

2. If applicable, termination of services without a referral to further services.

(7)(a) The treatment plan of a recipient who continues to receive services shall be reviewed at least once every six (6) months.

(b) Any change to a recipient's treatment plan shall be documented, signed, and dated by the rendering practitioner.

(8)(a) Notes regarding services to a recipient shall:

1. Be organized in chronological order;

2. Be dated;

3. Be titled to indicate the service rendered;

4. State a starting and ending time for the service; and

5. Be recorded and signed by the rendering practitioner and include the professional title (for example, licensed clinical social worker) of the provider.

(b) Initials, typed signatures, or stamped signatures shall not be accepted.

(c) Telephone contacts, family collateral contacts not covered under this administrative regulation, or other non-reimbursable contacts shall:

1. Be recorded in the notes; and

2. Not be reimbursable.

(9)(a) A termination summary shall:

1. Be required, upon termination of services, for each recipient who received at least three (3) service visits; and

2. Contain a summary of the significant findings and events during the course of

treatment including the:

a. Final assessment regarding the progress of the individual toward reaching goals and objectives established in the individual's treatment plan;

b. Final diagnosis of clinical impression; and

c. Individual's condition upon termination and disposition.

(b) A health record relating to an individual who terminated from receiving services shall be fully completed within ten (10) days following termination.

(10) If an individual's case is reopened within ninety (90) days of terminating services for the same or related issue, a reference to the prior case history with a note regarding the interval period shall be acceptable.

(11) If a recipient is transferred or referred to a health care facility or other provider for care or treatment, the transferring behavioral health services organization shall, within ten (10) business days of the transfer or referral, transfer the recipient's records in a manner that complies with the records' use and disclosure requirements as established in or required by:

(a)1. The Health Insurance Portability and Accountability Act;

2. 42 U.S.C. 1320d-2 to 1320d-8; and

3. 45 C.F.R. Parts 160 and 164; or

(b)1. 42 U.S.C. 290 ee-3; and

2. 42 C.F.R Part 2.

(12)(a) If a behavioral health services organization's Medicaid Program participation status changes as a result of voluntarily terminating from the Medicaid Program, involuntarily terminating from the Medicaid Program, a licensure suspension, or death of an

owner or deaths of owners, the health records of the behavioral health services organization shall:

1. Remain the property of the behavioral health services organization; and

2. Be subject to the retention requirements established in subsection (13) of this section.

(b) A behavioral health services organization shall have a written plan addressing how to maintain health records in the event of death of an owner or deaths of owners.

(13)(a) Except as established in paragraph (b) or (c) of this subsection, a targeted case management service shall maintain a case record regarding a recipient for at least six (6) years from the date of the service or until any audit dispute or issue is resolved beyond six (6) years.

(b) After a recipient's death or discharge from services, a provider shall maintain the recipient's record for the longest of the following periods:

1. Six (6) years unless the recipient is a minor; or

2. If the recipient is a minor, three (3) years after the recipient reaches the age of majority under state law.

(c) If the Secretary of the United States Department of Health and Human Services requires a longer document retention period than the period referenced in paragraph (a) of this section, pursuant to 42 C.F.R. 431.17, the period established by the secretary shall be the required period.

(14)(a) A behavioral health services organization shall comply with 45 C.F.R. Chapter 164.

(b) All information contained in a health record shall:

1. Be treated as confidential;

2. Not be disclosed to an unauthorized individual; and

3. Be disclosed to an authorized representative of:

a. The department; or

b. Federal government;

(c)1. Upon request, a behavioral health services organization shall provide to an authorized representative of the department or federal government information requested to substantiate:

a. Staff notes detailing a service that was rendered;

b. The professional who rendered a service; and

c. The type of service rendered and any other requested information necessary to determine, on an individual basis, whether the service is reimbursable by the department.

2. Failure to provide information referenced in subparagraph 1 of this paragraph shall result in denial of payment for any service associated with the requested information.

Section 7. Medicaid Program Participation Compliance. (1) A behavioral health services organization shall comply with:

(a) 907 KAR 1:671;

(b) 907 KAR 1:672; and

(c) All applicable state and federal laws.

(2)(a) If a behavioral health services organization receives any duplicate payment or overpayment from the department, regardless of reason, the behavioral health services organization shall return the payment to the department.

(b) Failure to return a payment to the department in accordance with paragraph (a) of

this section may be:

1. Interpreted to be fraud or abuse; and

2. Prosecuted in accordance with applicable federal or state law.

(3)(a) When the department makes payment for a covered service and the behavioral health services organization accepts the payment:

1. The payment shall be considered payment in full;

2. No bill for the same service shall be given to the recipient; and

3. No payment from the recipient for the same service shall be accepted by the behavioral health services organization.

(b)1. A behavioral health services organization may bill a recipient for a service that is not covered by the Kentucky Medicaid Program if the:

a. Recipient requests the service; and

b. Behavioral health services organization makes the recipient aware in advance of providing the service that the:

(i) Recipient is liable for the payment; and

(ii) Department is not covering the service.

2. If a recipient makes payment for a service in accordance with subparagraph 1 of this paragraph, the:

a. Behavioral health services organization shall not bill the department for the service; and

b. Department shall not:

(i) Be liable for any part of the payment associated with the service; and

(ii) Make any payment to the behavioral health services organization regarding the

service.

(4)(a) A behavioral health services organization attests by the behavioral health services organization's staff's or representative's signature that any claim associated with a service is valid and submitted in good faith.

(b) Any claim and substantiating record associated with a service shall be subject to audit by the:

1. Department or its designee;

2. Cabinet for Health and Family Services, Office of Inspector General or its designee;

3. Kentucky Office of Attorney General or its designee;

4. Kentucky Office of the Auditor for Public Accounts or its designee; or

5. United States General Accounting Office or its designee;

(c) If a behavioral health services organization receives a request from the department to provide a claim, related information, related documentation, or record for auditing purposes, the behavioral health services organization shall provide the requested information to the department within the timeframe requested by the department.

(d)1. All services provided shall be subject to review for recipient or provider abuse.

2. Willful abuse by a behavioral health services organization shall result in the suspension or termination of the behavioral health services organization from Medicaid Program participation.

Section 8. Third Party Liability. A behavioral health services organization shall comply with KRS 205.622.

Section 9. Use of Electronic Signatures. (1) The creation, transmission, storage, and

other use of electronic signatures and documents shall comply with the requirements established in KRS 369.101 to 369.120.

(2) A behavioral health services organization that chooses to use electronic signatures shall:

(a) Develop and implement a written security policy that shall:

1. Be adhered to by each of the behavioral health services organization's employees, officers, agents, or contractors;

2. Identify each electronic signature for which an individual has access; and

3. Ensure that each electronic signature is created, transmitted, and stored in a secure fashion;

(b) Develop a consent form that shall:

1. Be completed and executed by each individual using an electronic signature;

2. Attest to the signature's authenticity; and

3. Include a statement indicating that the individual has been notified of his responsibility in allowing the use of the electronic signature; and

(c) Provide the department, immediately upon request, with:

1. A copy of the behavioral health services organization's electronic signature policy;

2. The signed consent form; and

3. The original filed signature.

Section 10. Auditing Authority. The department shall have the authority to audit any:

(1) Claim;

(2) Medical record; or

(3) Documentation associated with any claim or medical record.

Section 11. Federal Approval and Federal Financial Participation. The department's coverage of services pursuant to this administrative regulation shall be contingent upon:

(1) Receipt of federal financial participation for the coverage; and

(2) Centers for Medicare and Medicaid Services' approval for the coverage.

Section 12. Appeals. (1) An appeal of an adverse action by the department regarding a service and a recipient who is not enrolled with a managed care organization shall be in accordance with 907 KAR 1:563.

(2) An appeal of an adverse action by a managed care organization regarding a service and an enrollee shall be in accordance with 907 KAR 17:010.

907 KAR 15:020E

REVIEWED:

6/3/14
Date

Lawrence Kissner, Commissioner
Department for Medicaid Services

APPROVED:

7/8/14
Date

Audrey Tayse Haynes
Audrey Tayse Haynes, Secretary
Cabinet for Health and Family Services

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Administrative Regulation: 907 KAR 15:020E
Contact person: Stuart Owen (502) 564-4321

(1) Provide a brief summary of:

(a) What this administrative regulation does: This new administrative regulation establishes the coverage provisions and requirements regarding Medicaid Program behavioral health services provided by behavioral health services organizations (BHSOs). This administrative regulation is being promulgated in conjunction with 907 KAR 15:025, Reimbursement for behavioral health services provided by behavioral health services organizations. To qualify as a provider, a behavioral health services organization must be licensed in accordance with 902 KAR 20:430. BHSOs are authorized to provide, to Medicaid recipients, behavioral health services related to a mental health disorder, substance use disorder, or co-occurring disorders. The array of services includes a screening; an assessment; psychological testing; crisis intervention; mobile crisis services; day treatment; peer support; intensive outpatient program services; individual outpatient therapy; group outpatient therapy; family outpatient therapy; collateral outpatient therapy; service planning; residential services for a substance use disorder; a screening, brief intervention, and referral to treatment for a substance use disorder; assertive community treatment; comprehensive community support services; and therapeutic rehabilitation program services.

(b) The necessity of this administrative regulation: This administrative regulation is necessary - to comply with federal mandates. Section 1302(b)(1)(E) of the Affordable Care Act mandates that "essential health benefits" for Medicaid programs include "mental health and substance use disorder services, including behavioral health treatment" for all recipients. 42 U.S.C. 1396a(a)(23), is known as the freedom of choice of provider mandate. This federal law requires the Medicaid Program to "provide that (A) any individual eligible for medical assistance (including drugs) may obtain such assistance from any institution, agency, community pharmacy or person, qualified to perform the service or services required (including an organization which provides such services, or arranges for their availability, on a prepayment basis), who undertakes to provide him such services." 42 U.S.C. 1396a(a)(10)(B) requires the Medicaid Program to ensure that services are available to Medicaid recipients in the same amount, duration, and scope. Expanding the provider base (to include behavioral health services organizations) will help ensure Medicaid recipient access to services statewide and reduce or prevent the lack of availability of services due to demand exceeding supply in any given area.

(c) How this administrative regulation conforms to the content of the authorizing statutes: This administrative regulation conforms to the content of the authorizing statutes by complying with federal mandates and enhancing and ensuring Medicaid recipients' access to behavioral health services.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation will assist in the effective administration of the authorizing statutes by complying with federal mandates and enhancing and ensuring Medicaid recipients' access to behavioral health services.

(2) If this is an amendment to an existing administrative regulation, provide a brief summary of:

(a) How the amendment will change this existing administrative regulation: This is a new administrative regulation rather than an amendment.

(b) The necessity of the amendment to this administrative regulation: This is a new administrative regulation rather than an amendment.

(c) How the amendment conforms to the content of the authorizing statutes: This is a new administrative regulation rather than an amendment.

(d) How the amendment will assist in the effective administration of the statutes: This is a new administrative regulation rather than an amendment.

(3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: Entities licensed as behavioral health services organizations will be affected by this administrative regulation. Currently, there are forty-six (46) entities that provide behavioral health services via DMS's "Impact Plus" program. These entities provide such services as subcontractors of the Department for Behavioral Health, Intellectual and Developmental Disabilities (DBHDID) or the Department for Community Based Services (DCBS.) DMS anticipates that each of the entities will enroll as in the Medicaid Program as BHSOs. Additionally, the following behavioral health professionals who are authorized to provide services in a behavioral health services organization will be affected: licensed psychologists, advanced practice registered nurses, licensed professional clinical counselors, licensed clinical social workers, licensed marriage and family therapists, licensed psychological practitioners, licensed psychological associates, certified social workers, licensed professional counselor associates, marriage and family therapy associates, licensed behavior analysts, licensed assistant behavior analysts, licensed professional art therapists, licensed professional art therapist associates, certified alcohol and drug counselors, peer support specialists, and community support associates. Medicaid recipients who qualify for behavioral health services will also be affected by this administrative regulation.

(4) Provide an analysis of how the entities identified in question (3) will be impacted by either the implementation of this administrative regulation, if new, or by the change, if it is an amendment, including:

(a) List the actions that each of the regulated entities identified in question (3) will have to take to comply with this administrative regulation or amendment. Entities that qualify as behavioral health services organizations and who wish to provide services to Medicaid recipients will need to enroll with the Medicaid Program as prescribed in the Medicaid provider enrollment regulation (complete an application and submit it to DMS) and sign agreements with managed care organizations if the individual wishes to provide services to Medicaid recipients who are enrolled with a managed care organization.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3). The entities referenced in paragraph (a) could experience administrative costs associated with enrolling with the Medicaid Program.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3). The entities referenced in paragraph (a) will benefit by receiving Medicaid

Program reimbursement. Behavioral health professionals authorized to provide services in a behavioral health services organization will benefit by having more employment opportunities in Kentucky. Medicaid recipients in need of behavioral health services will benefit from an expanded base of providers from which to receive these services.

(5) Provide an estimate of how much it will cost to implement this administrative regulation:

(a) Initially: DMS is unable to accurately estimate the costs of expanding the behavioral health provider base due to the variables involved as DMS cannot estimate the utilization of these services in BHSOs compared to utilization in other authorized provider settings (independent behavioral health providers, community mental health centers, federally-qualified health centers, rural health clinics, and primary care centers. However, an actuary with whom DMS contracted has estimated an average per recipient per month increase (to DMS) of $27.00 associated with DMS's expansion of behavioral health services (including substance use disorder services) as well as behavioral health providers this year.

(b) On a continuing basis: The response in paragraph (a) also applies here.

(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: The sources of revenue to be used for implementation and enforcement of this administrative regulation are federal funds authorized under the Social Security Act, Title XIX and matching funds of general fund appropriations.

(7) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an amendment. Neither an increase in fees nor funding is necessary to implement this administrative regulation.

(8) State whether or not this administrative regulation establishes any fees or directly or indirectly increases any fees: This administrative regulation neither establishes nor increases any fees.

(9) Tiering: Is tiering applied? Tiering is not applied as the policies apply equally to the regulated entities.

FEDERAL MANDATE ANALYSIS COMPARISON

Administrative Regulation: 907 KAR 15:020E
Contact person: Stuart Owen (502) 564-4321

1. Federal statute or regulation constituting the federal mandate. Section 1302(b)(1)(E) of the Affordable Care Act, 42 U.S.C. 1396a(a)(10)(B), and 42 U.S.C. 1396a(a)(23).

2. State compliance standards. KRS 205.520(3) states: "Further, it is the policy of the Commonwealth to take advantage of all federal funds that may be available for medical assistance. To qualify for federal funds the secretary for health and family services may by regulation comply with any requirement that may be imposed or opportunity that may be presented by federal law. Nothing in KRS 205.510 to 205.630 is intended to limit the secretary's power in this respect."

3. Minimum or uniform standards contained in the federal mandate. Substance use disorder services are federally mandated for Medicaid programs. Section 1302(b)(1)(E) of the Affordable Care Act mandates that "essential health benefits" for Medicaid programs include "mental health and substance use disorder services, including behavioral health treatment." 42 U.S.C. 1396a(a)(23), is known as the freedom of choice of provider mandate. This federal law requires the Medicaid Program to "provide that (A) any individual eligible for medical assistance (including drugs) may obtain such assistance from any institution, agency, community pharmacy or person, qualified to perform the service or services required (including an organization which provides such services, or arranges for their availability, on a prepayment basis), who undertakes to provide him such services." Medicaid recipients enrolled with a managed care organization may be restricted to providers within the managed care organization's provider network. The Centers for Medicare and Medicaid Services (CMS) – the federal agency which oversees and provides the federal funding for Kentucky's Medicaid Program – has expressed to the Department for Medicaid Services (DMS) the need for DMS to expand its substance use disorder provider base to comport with the freedom of choice of provider requirement. 42 U.S.C. 1396a(a)(10)(B) requires the Medicaid Program to ensure that services are available to Medicaid recipients in the same amount, duration, and scope as available to other individuals (non-Medicaid.) Expanding the provider base will help ensure Medicaid recipient access to services statewide and reduce or prevent the lack of availability of services due to demand exceeding supply in any given area.

4. Will this administrative regulation impose stricter requirements, or additional or different responsibilities or requirements, than those required by the federal mandate? The administrative regulation does not impose stricter than federal requirements.

5. Justification for the imposition of the stricter standard, or additional or different responsibilities or requirements. The administrative regulation does not impose stricter than federal requirements.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

Administrative Regulation: 907 KAR 15:020E
Contact person: Stuart Owen (502) 564-4321

1. What units, parts or divisions of state or local government (including cities, counties, fire departments, or school districts) will be impacted by this administrative regulation? The Department for Medicaid Services will be affected by the amendment to this administrative regulation.

2. Identify each state or federal regulation that requires or authorizes the action taken by the administrative regulation. This administrative regulation authorizes the action taken by this administrative regulation.

3. Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is to be in effect.

(a) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for the first year? The amendment is not expected to generate revenue for state or local government.

(b) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for subsequent years? The amendment is not expected to generate revenue for state or local government.

(c) How much will it cost to administer this program for the first year? DMS is unable to accurately estimate the costs of expanding the behavioral health provider base due to the variables involved as DMS cannot estimate the utilization of these services in BHSOs compared to utilization in other authorized provider settings (independent behavioral health providers, community mental health centers, federally-qualified health centers, rural health clinics, and primary care centers. However, an actuary with whom DMS contracted has estimated an average per recipient per month increase (to DMS) of $27.00 associated with DMS's expansion of behavioral health services (including substance use disorder services) as well as behavioral health providers this year.

(d) How much will it cost to administer this program for subsequent years? The response to question (c) also applies here.

Note: If specific dollar estimates cannot be determined, provide a brief narrative to explain the fiscal impact of the administrative regulation.

Revenues (+/-):
Expenditures (+/-):
Other Explanation: